NYS Continuation Assistance Program

Application for Entertainment Industry Employees

This program assists eligible entertainment industry employees in maintaining their health coverage. Eligible applicants can receive premium assistance equal to 50% of their COBRA premiums for up to 12 months.

Application Instructions

SECTION 1 Applicant Information

Please provide your contact information. You must be a New York State resident to receive premium assistance through this program.

SECTION 2 Entertainment Industry Information

To qualify for this program, you must be currently receiving or eligible for COBRA continuation coverage through an entertainment industry union fund. Please provide your entertainment industry union fund information in Section 2.

SECTION 3 COBRA Continuation Coverage

Please answer the questions in Section 3 about your COBRA continuation coverage, including the first month for which you are seeking premium assistance. We cannot provide retroactive premium assistance.

Please attach documentation of your COBRA continuation coverage eligibility.

SECTION 4 Household Income

In order to qualify for the NYS Continuation Assistance Program, your household income must fall within the limits established for the program. Please list your current **gross** monthly income and the current **gross** monthly income of your spouse (if residing in your household) in the space provided.

Important -- Please use your income from the **previous full calendar month only**. All income must be counted, not just entertainment related income.

Please include wages, salary, self-employment income, interest and dividends, social security income, retirement income, alimony, unemployment benefits, workers compensation, rental income, royalties and residual payments. Please **do not** include gifts, public assistance, supplemental security income (SSI), foster care payments or child support payments you receive.

The NYS Continuation Assistance Program income limitations vary by household size. Refer to the chart on page 4 to determine if you meet the household income requirements.

Please attach documentation of your gross household income for the previous full calendar month.

SECTION 5 Certification

Please carefully review and complete the certification in Section 5.

SUBMITTING YOUR APPLICATION

Important – Please review your application and ensure that each section has been fully completed.

You may submit your application and documentation to: COBRA.application@dfs.ny.gov

OR

NYS Continuation Assistance Program
NYS Department of Financial Services
One Commerce Plaza, Suite 1909
Albany, NY 12257

For more information, please visit: www.dfs.ny.gov and search for "COBRA entertainment."

QUESTIONS?

Please call (518) 486-7815 or e-mail us at COBRA.application@dfs.ny.gov

Confidentiality Statement: All of the information you provide on this application will remain confidential. The information will only be provided to the state agencies that oversee the program, process payments or conduct audits.

NYS Continuation Assistance Program

Application for Entertainment Industry Employees

SECTION 1 Applicant Information

Legal Name: First _____ MI ____ Last _____			
Stage Name (if applicable):			
Telephone No.: ( )	Email Address:		
Home Address (Residence): Street			
City	State	Zip	County
Mailing Address (if different than home address): Street			
City	State	Zip	County
Are you a New York State resident? ☐ Yes ☐ No			

SECTION 2 Entertainment Industry Information

1. You must be currently eligible for, or receiving, COBRA continuation coverage from an entertainment industry union. (Note: if this does not apply to you, you are not eligible for this program.)

   Please provide the following information about your union fund membership:

   Union Fund Name: _____

   Union Fund Address: _____

   _____

   _____

2. Have you applied to this COBRA assistance program before? ☐ Yes ☐ No

3. Please provide a brief description of your most recent entertainment job:

   _____

   _____

   _____

   _____

SECTION 3 COBRA Continuation Coverage Information

1. Please provide the date you became or will become eligible for COBRA continuation coverage:

   _____

2. Please provide the date when your eligibility for COBRA continuation coverage ends:

   _____

3. Please indicate the first month for which you are seeking COBRA premium assistance: _____

   IMPORTANT: Premium assistance cannot be provided for prior months.

4. Please provide the full amount of your COBRA continuation insurance premium: $_____

   This premium is due every: ☐ Month ☐ Quarter ☐ Other (please explain) _____

   _____

5. Please attach a copy of the notification letter provided by your union fund stating your COBRA continuation coverage eligibility. This letter must include the dates for which you are eligible for COBRA continuation coverage. Do not send a certificate of creditable coverage.

   Notification letter attached? ☐ Yes ☐ No

6. Please provide the number of people (including yourself) who will be covered by the COBRA continuation policy: _____.

SECTION 4 Household Income

1. Please list the **monthly gross income** for both you and your spouse for the **previous full calendar month only.** (For example, if you are applying in February, please provide gross income for January.) Please include all income received in the **previous full calendar month**, regardless of when the income was earned. (For example: if a paycheck is dated 11/1 but the pay period is 10/24-10/31, this would count toward November income.) **You must include exact income, not an estimate**.

   Please include wages, salary, interest and dividends, self-employment income, social security income, retirement income, alimony, unemployment benefits, workers compensation, rental income, royalties and residual fees. Please **do not** include gifts, public assistance, supplemental security income (SSI), foster care payments or child support received.

   To qualify for the NYS Continuation Assistance program your household income must fall below the limits in the chart below. **All income is to be counted, including any non-entertainment related income.**

Family Size	Monthly Household Income
1	Up to $ 2,683
2	Up to $ 3,629
3	Up to $ 4,575
4	Up to $ 5,521
5	Up to $ 6,467
Extra person	Add $ 946

Amounts updated annually.

Applicant's Monthly Gross Income $_____

Spouse's Monthly Gross Income $_____

Total $**_____

**** If you have indicated $0 income above or your documentation only represents a partial month, please explain below.**

_____

_____

_____

_____

_____

2. **IMPORTANT!** You must attach documentation of your household income for the previous full calendar month. See the Application Instructions on page 1. Applications without complete documentation will not be processed. The following are examples of acceptable documentation:

- ☐ Copies of pay stubs, paychecks, or gross earnings statements
- ☐ Printout of unemployment payments
- ☐ Self-employment documents (i.e., bank statements, business records, invoices, etc.)
- ☐ Bank account statements
- ☐ Statements from Venmo, PayPal, or similar online payment mechanisms.
- ☐ Other (please explain)

_____

_____

_____

3. The household income limits vary depending upon your family size. Please provide the number of people in your family: _____.

   For the purposes of this program "family" means yourself, your spouse (if residing in your household) and any dependents eligible for coverage under your policy. Please note that the number of people in your family does not need to be the same as the number of people being covered under your COBRA insurance. (In other words, count your spouse, even if you are seeking coverage only for yourself.)

SECTION 5 Certification (Important – please read carefully)

By signing this certification of eligibility, I certify under penalty of perjury that all statements and answers contained in this certification are true.

I further certify that I am ineligible for Medicare and I am not receiving other COBRA premium assistance.

I acknowledge that I will lose my eligibility for premium assistance on the date that any of the following occur:

- My continuation coverage/COBRA ends;
- I move outside of New York State;
- I become eligible for Medicare; or
- I become eligible for employer coverage or union-sponsored health coverage.

I will immediately notify the NYS Continuation Assistance Program of any changes to the above information:

by email to: COBRA.application@dfs.ny.gov

or in writing addressed to:

NYS Continuation Assistance Program
NYS Department of Financial Services
One Commerce Plaza, Suite 1909
Albany, NY 12257

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature_____ Date_____

Send this application and documentation:

By email: COBRA.application@dfs.ny.gov

OR by mail:

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NYS Department of Financial Services
One Commerce Plaza, Suite 1909
Albany, NY 12257